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Sir,

'A Thrip to eye casualty' an unusal complication of Sub-Tenon's anaesthesia

Many of the complications of cataract surgery have been solved through the evolution of surgical and anaesthetic technique. The majority of cases today are performed as a day case under local anaesthetic, which may be administered topically, in to the Sub-Tenon's space or given as peribulbar block. The safety and efficiency of Sub-Tenon's anaesthesia is well documented.[1] We present an unusual complication of Sub-Tenon's anaesthesia following routine cataract surgery.

Case Report

A 69-year-old man presented, 18 days following uncomplicated cataract surgery under Sub-Tenon's anaesthesia, with a 2-week history of a painless red eye. He had been picking blackcurrants at the onset of symptoms. He was known to be on long-term warfarin therapy following an aortic valve replacement. On examination his best-corrected Snellen visual acuity was 6/6 and a nasal subconjunctival haemorrhage was noted (Figure 1a). Slit-lamp examination revealed an intact subconjunctival insect associated with the subconjunctival haemorrhage located above the area that the Sub-Tenon's anaesthesia had been administered (Figure 1b). The rest of the ocular examination was normal. An uncomplicated removal of the insect was performed *via* a small conjunctival incision and the subconjunctival haemorrhage resolved. The insect has been identified as a Thrips (order Thysanoptera meaning 'fringed wings'). Although tiny they may occur in large numbers, and are also know as 'thunder flies' because they often fly on warm, still (eg prethunder-storm) days. Thrips commonly inhabit flowerheads and feed on plant sap.

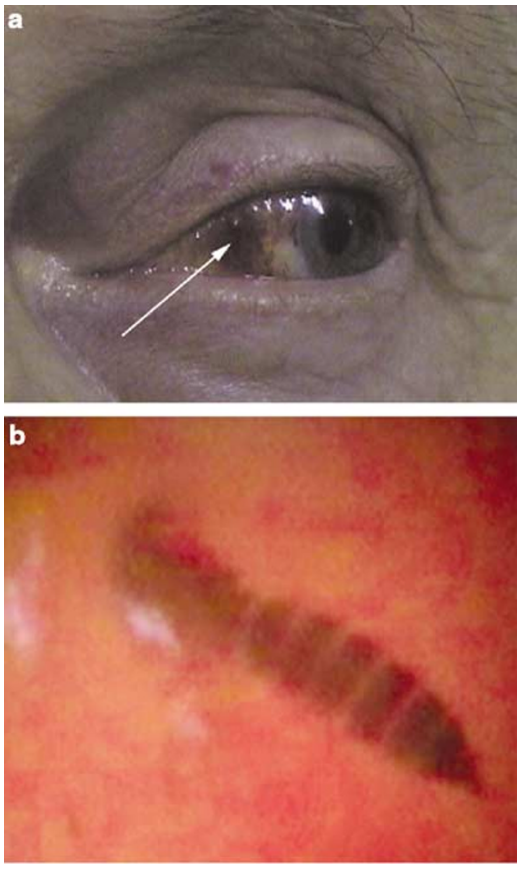

Figure 1 Subconjunctival haemorrhage adjacent to the entry site of the Sub-Tenon's anaesthetic block. When viewed with higher magnification a small subconjunctival insect could be seen, this was later identified as 'Thrips'.

Comment

Sub-Tenon's anaesthesia is an established and safe technique but involves incising the conjunctiva to access the Sub-Tenon's space, if as in this case the incision is

large and sited too anteriorly it presents a potential porthole for unwanted foreign bodies.[1,2] There have been numerous case reports of the consequences of injury from hymenopteran insects, caterpillar setae, and insect wings.[3,4] However, we understand that this is the first report of insect entrapment in the subconjunctival space following Sub-Tenon's anaesthesia. Following cataract surgery, patients are instructed not to rub their eyes. This may explain why the insect was not wiped away after initial entrapment. Subconjunctival haemorrhages are common in patients taking oral anticoagulants who undergo Sub-Tenon's anaesthesia, and this presents as an unusual precipitant. Care should be taken when administering Sub-Tenon's anaesthesia to ensure that the conjunctival incision is small and sited correctly so as to minimise the potential complication of foreign bodies as illustrated in this case.

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Sir,

Acute angle closure in Miller Fisher syndrome

Guillain–Barre syndrome is an acute inflammatory demyelinating polyneuropathy often triggered by a preceding infection,[1] of which Miller Fisher syndrome (MFS), characterized by the clinical triad of ophthalmoplegia, ataxia, and areflexia, is considered to be a variant.[2] Nearly half of patients with MFS demonstrate decreased pupillary reactions and mydriasis.[3] A literature search did not reveal any reports of an association between MFS and acute angle closure (AAC). We therefore describe the first case of MFS as the precipitating factor for an attack of AAC.

Case report

A 64-year-old man presented with a 5-day history of ataxia, and diplopia with a preceding malaise and general myalgia. Initial neurological examination demonstrated dysarthria, bilateral positive cerebellar signs, weak proximal muscle groups, hyporeflexia, and hypertonia, with reduced sensation to light touch, vibration, and joint position. Cardiovascular examination revealed autonomic instability with hypertension 210/120 mmHg and tachycardia (100 bpm). Abdominal and respiratory examinations were normal. Ocular movements were reduced in abduction bilaterally, and there was a left ptosis. Pupillary reactions were equal but poorly reactive to light and accommodation, remaining mid-dilated. A diagnosis of Miller–Fisher variant of Guillain–Barre syndrome was made and intravenous pooled immunoglobulins commenced.

At 4 days into his admission, he complained of a reduction in left visual acuity and was referred to the ophthalmology on-call team. Initial examination revealed a vision of hand movements in the left eye and 6/9 in the right eye without improvement, and bilateral sixth nerve palsies. There was mild conjunctival injection, left corneal oedema, bilateral mid-dilated pupils, and intraocular pressures were 20 mmHg on the right and 56 mmHg on the left eye. Gonioscopy revealed closed angles on the left and Schaffer grade 1 angle on the right; the anterior chambers were shallow centrally, the crystalline lens was clear. Treatment commenced with g-timolol BD, g-iopidine TDS, g-latanoprost nocte, and oral acetazolamide 250 mg QDS. The next day, his pressures were 13 mmHg in the right eye and 6 mmHg in the left eye. Bilateral YAG laser peripheral iridotomies were performed. Subsequently, his vision has improved to 6/6 OD and 6/12 OS, with refractive correction of $+1.25$DS/$+0.25$DC $\times 99^{\circ}$ OD and $+4.00$DS/$+0.25$DC $\times 51^{\circ}$ OS. His axial lengths were 22.68 mm in the right eye and 21.60 mm in the left eye with anterior chamber depths being 2.64 mm in the right eye and 2.59 mm in the left eye.

Comment

Primary angle closure results from peripheral iris apposition with the trabecular meshwork, creating an